Learning from an asthma near miss in southeast London

10-year-old year old girl admitted with **ACUTE LIFE-THREATENING ASTHMA** (SEL 2024).

Child in need.
Named social worker, did not know about her asthma diagnosis and that she had not been brought to appointments.

140 salbutamol inhalers in the last 5 years.

41 GP appointments for prescriptions requests alone.

Was not brought to outreach appointment.

Referred to community asthma service, was not brought three times and so **discharged.**

Watch this short animation

Rethink 'Did Not Attend'

Poorly controlled asthma is a long-term condition with high risk for death, hospital admission and school absence, compounded by difficult social circumstances e.g. poor housing and mental health issues.

ACTIONS FOR CLINICAL TEAMS

To reduce risks of poor outcomes, especially for vulnerable children and young people

Highlight the benefits of good asthma control and the risks of non-engagement when inviting patients to appointments, that attending appointments increases opportunity for good asthma care – enabling people with asthma to lead full and active lives and reduces the risk of becoming very unwell and needing emergency hospital care.

Inform parents/carers of children who are not brought to appointments, that a safeguarding referral will be considered and act on this if necessary.

Ensure you have a clear 'child not brought' pathway and this is adhered to.

FOR COMMUNITY AND SECONDARY CARE ASTHMA TEAMS

Teams to review records before discharging from service.

FOR GENERAL PRACTICE TEAMS

For those at risk of poorly controlled asthma – e.g. safeguarding concerns, repeatedly not brought, overuse of salbutamol – clinician to contact directly by phone to invite for review – rather than via text or letter.

Full team to be aware of SABA overuse alerts and know what steps to take.

Contact CESEL for asthma education and support to use searches to identify high risk patients.

Those involved in this near miss valued coming together – from general practice, community team, specialist team and social care – to share their learning and think how we can work collaboratively to reduce the risk of similar near misses in the future. Reach out to colleagues to share learning if you are involved in a similar case going forward.

For comments or feedback contact clinicaleffectiveness@selondonics.nhs.uk.

This slide captures the learning from SEL colleagues across services coming together and with the child and her family sharing learning to reduce the risk of similar events in the future.
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